Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 08051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 852 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 852 Maryland Ave.

3. NAME OF DECEASED: (First) Albert (Middle) (Last) Aberle
4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 19 54
5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: May 19-1868
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): retired Conductor
10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Mathias Aberle
14. MOTHER'S MAIDEN NAME: Elizabeth Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: (wife) Flora Aberle, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

450.0

Immediate cause (a) Generalized arteriosclerosis (senility) — Interval between onset and death: Gradual

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H.V. Deming M.D. H.V. Deming M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D.
DATE SIGNED: Jan. 26-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan 28, 1954
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem
LOCATION (City, town, or county) (State): Cumberland, Maryland
DATE REC'D BY LOCAL REG.: Jan. 27, 1954
REGISTRAR'S SIGNATURE: Victor K. Frantz, M.D.
23. FUNERAL DIRECTOR: John J. Lafer, "
ADDRESS: "

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00029

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22
LENGTH OF STAY (in this place) 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Ormond St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22
STREET ADDRESS (If rural give location) Rear 50 Ormond Street,

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Keirs (Last) Arnold

4. DATE OF DEATH: (Month) 1 (Day) 26 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Aug. 8th, 1874

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Keirs

14. MOTHER'S MAIDEN NAME: Janet Morton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 9

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Anthony Ritchie, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

293X

Immediate cause (a) Anemia, Type Undetermined DUE TO — Interval Between Onset And Death: 2-3 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. old age

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN., 1954, to JAN., 1954, that I last saw the deceased alive on 1/26, 1954, and that death occurred at 2:45 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) John C Deven M.D. ADDRESS Frostburg Md DATE SIGNED 1/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan. 28th, 54

NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park

LOCATION (City, town, or county) Frostburg, (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-28-54

REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Joseph R. Durst, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Within corporate limits: DR. R. WMS.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00003

CERTIFICATE OF DEATH

Reg. Dist. No. 4

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENN. — COUNTY Erie
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ERIE
STREET ADDRESS (If rural give location) 3430 GLENSIDE AVE.

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	ROBERT	P.	BEATTY	JAN	26	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
MALE	WHITE	WIDOWED	JULY 31, 1861	92 yrs.	5	25		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Day Dy.	Workman (Retired)	[redacted] Iowa	U.S.A.

13. FATHER'S NAME: ROBERT BEATTY

14. MOTHER'S MAIDEN NAME: [illegible] ELIA KELLY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	—	None	MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause (Final disease or condition resulting in death) 491.8	(a) Bronchopneumonia	1 wk
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ravages of extreme age — —

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0 —	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	Cumberland	Alley	Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURED While at Work ☐	Not While At Work ☐	HOW DID INJURY OCCUR?
—			m.			—

22. I hereby certify that I attended the deceased from 1/5/54, 19..., to 1/26/54, 19..., that I last saw the deceased alive on 1/26/54, 19..., and that death occurred at 10:10AM, from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
J. Williams M.D.	Cumberland Md	1/26/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 28 54	Terra Alta Cem	Terra Alta	W. Va

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 26, 1954	Winter K. Frank, M.D.	P.R. Wilson, Terra Alta W. Va	

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr N. Reeves

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Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton; MARYLAND; LENGTH OF STAY (In this place) 80 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) DAVID (Middle) SMITH (Last) BOAL

4. DATE OF DEATH: (Month) January (Day) 30 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 12 1873

9. AGE last birthday: 80 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Funeral Director

10b. KIND OF BUSINESS OR INDUSTRY: Funeral

11. BIRTHPLACE (State or foreign country): Barton, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Boal

14. MOTHER'S MAIDEN NAME: Jane Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Ellsworth S. Boal, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (420.1)	(a) Acute Coronary Occlusion	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Vascular-renal disease	3 yr
	(c) Chronic Gout	20 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/28, 1954, to 1/30, 1954, that I last saw the deceased alive on 1/29, 1954, and that death occurred at 5:10 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Norman Reeves M.D ADDRESS Westernport Md DATE SIGNED 2/1/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 2-2-54

NAME OF CEMETERY OR CREMATORY: Philos Cemetery

LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Feb. 2, 1954

REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly

24. FUNERAL DIRECTOR ADDRESS: Charles L. George, Cumberland, Md.

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Within corporate limits

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DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02 — LENGTH OF STAY (in this place) 1 DAY	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location) 19 OFFUTT STREET

3. NAME OF DECEASED: (Type or Print) (First) BABY BOY (Middle) (Last) BOWER

4. DATE OF DEATH: (Month) JAN. (Day) 24 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: JAN. 24, 1954

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 11, Min. 50

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HOWARD RAY BOWER

14. MOTHER'S MAIDEN NAME: JOSEPHINE PUFFENBERGER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776 X

Immediate cause (a) Prematurity. 28 weeks Gestation? — Interval Between Onset And Death 12 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1954, to 1-24, 1954, that I last saw the deceased alive on 1-24, 1954, and that death occurred at 11:00 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) H. W. Eliason M.D. — ADDRESS 126 Union St. Cumberland Md. — DATE SIGNED 1/25/54

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation — DATE THEREOF Jan. 25, 1954 — NAME OF CEMETERY OR CREMATORY Memorial Hospital — LOCATION (City, town, or county) Cumberland, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 25, 1954 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Memorial Hospital, " — ADDRESS "

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within the corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0003 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND LENGTH OF STAY (in this place): 4 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route #6, Cumberland Rural
STREET ADDRESS (If rural give location): Near Spring R.F.D. #4, Brice Hollow Road, Gap

3. NAME OF DECEASED: (Type or Print) (First) Libby (Middle) Virginia (Last) Buckley

4. DATE OF DEATH: (Month) January (Day) 18, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 9, 1880

9. AGE last birthday: 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Glebe, West Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George G. Clower

14. MOTHER'S MAIDEN NAME: Mary Hammond

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) None

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Otto M. Buckley, Rt. 4, Cumberland, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) 442X Hypertensive C.V. Renal Disease	3 yrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cerebral Hemorrhage	4 days
	DUE TO (c) Uremia	4 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. **INJURY OCCURED** While at Work ☐ Not While At Work ☐ **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Jan. 12, 1954, to Jan. 18, 1954, that I last saw the deceased alive on Jan. 18, 1954, and that death occurred at 3:25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. M. Schmidt M.D. ADDRESS 44 Greene St. Cumberland, Md. DATE SIGNED 1/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial **DATE THEREOF** Jan. 21, 1954 **NAME OF CEMETERY OR CREMATORY** St. Luke's Cemetery **LOCATION** (City, town, or county) Glebe, West Virginia (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 20, 1954 **REGISTRAR'S SIGNATURE** Walter L. Feaby M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, **ADDRESS** Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

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DR. R. J. WILLIAMS

Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

LENGTH OF STAY (in this place): 5 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND COUNTY: ALLEGANY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

STREET ADDRESS (If rural give location): 138 MARY STREET

3. NAME OF DECEASED: (Type or Print) (First) LILLIE (Middle) D. (Last) BURCH

4. DATE OF DEATH: (Month) JANUARY (Day) 26, (Year) 19 54

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: AUGUST 27, 1877

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL MARSHALL

14. MOTHER'S MAIDEN NAME: JANE S. BUCKLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 157X Carcinoma of Pancreas — Interval Between Onset And Death: 6 mos.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis & Age -

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) Cumberland Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 6/12/52, 19..., to 1/26/54, 19..., that I last saw the deceased alive on 1/26/54, 19..., and that death occurred at 10:50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Williams M.D. ADDRESS Cumberland DATE SIGNED 1/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan. 29 1954

NAME OF CEMETERY OR CREMATORY Asbury Cemetery

LOCATION (City, town, or county) (State) Fabius, W. Va.

DATE REC'D BY LOCAL REGISTRAR Jan 28, 1954

REGISTRAR'S SIGNATURE Walter R. Leary, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.

ADDRESS

VS. A15

0058

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0008

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A11

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg - 2
LENGTH OF STAY (in this place): 1 Night
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Finzel,
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (Type or Print) (First) Richard (Middle) (Last) Burdock

4. DATE OF DEATH: (Month) Jan (Day) 30 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 13, 1885

9. AGE last birthday: 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Ret. Clayminer

10b. KIND OF BUSINESS OR INDUSTRY: Fireclay

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Burdock

14. MOTHER'S MAIDEN NAME: Agnes Morrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Lawrence Carey, Finzel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) 422.1 Chronic Myocardial Insufficiency — Interval Between Onset And Death: 24 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO — (b) Arteriosclerosis — ?

DUE TO — (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1953, to Jan 30, 1954, that I last saw the deceased alive on Jan 29, 1954, and that death occurred at 5:00 A, from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm A Lane MD — ADDRESS: Frostburg Md — DATE SIGNED: Jan 30 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2-1-1954 — NAME OF CEMETERY OR CREMATORY: Johnson's Cemetery — LOCATION (City, town, or county): Garrett County, — (State): Md.

DATE REC'D BY LOCAL REGISTRAR: 2-1-54 — REGISTRAR'S SIGNATURE: Dudley N. Roe

24. FUNERAL DIRECTOR — ADDRESS: Joseph R. Durst, Frostburg, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ... ...

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) near, Old Town
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route #1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) near, Old Town
STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) William (Last) Buser

4. DATE OF DEATH (Month) Jan. (Day) 14 (Year) 1954

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: Oct. 17-1869
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Short Gap, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Buser
14. MOTHER'S MAIDEN NAME: Marie Sinn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: (son) Thomas W. Buser, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Chronic myocarditis also had — several years.
DUE TO (c) Arteriosclerosis — "

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED Jan. 15-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Jan. 17-1954
NAME OF CEMETERY OR CREMATORY Mt. Olive Methodist Cemetery
LOCATION (City, town, or county) Rural near, Old Town (State) Md.

DATE REC'D BY LOCAL REG. Jan. 16, 1954
REGISTRAR'S SIGNATURE Mrs. Fay Duckworth
21. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15A - 5 - 53

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Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

DR. WHITWORTH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 9 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 16 NORTH LEE STREET

3. NAME OF DECEASED: (Type or Print) (First) JOANNE (Middle) B. (Last) CLAIR

4. DATE OF DEATH: (Month) JANUARY (Day) 21, (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: JANUARY 10, 1933
9. AGE last birthday: 21 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL MC GANN
14. MOTHER'S MAIDEN NAME: GENEVIEVE HUGHES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset And Death

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Shock — Hemmorage

DUE TO (c) Delivery Macerated Fetus - ~~Multiple Abortions~~ (4½ months)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. multiple spont. abortions afbrihirgenosis -

19a. DATE OF OPERATION: 12 Jan 54
19b. MAJOR FINDINGS OF OPERATION: Complete Fibosis Uters - Uterine Atony
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Jan, 1954, to 21 Jan, 1954, that I last saw the deceased alive on 20 Jan, 1954, and that death occurred at 2:05 A.M., from the causes and on the date stated above.

SIGNATURE Fuller B Whitworth (Degree or title) M.D. ADDRESS 173 Bedford St Cumberland Md DATE SIGNED 22 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan 23/54
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 22, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H Kight ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00018

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Hagerstown
LENGTH OF STAY (In this place) 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. No 1 Frostburg, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) R.D. No 1 Frostburg, Md

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Elizabeth (Last) Eleck
4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIR: Oct. 17-1883
9. AGE Last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Home maker
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Lonaconing Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Orlan Castle
14. MOTHER'S MAIDEN NAME: Elizabeth Delaney

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) 1 (If Yes, give war or dates of service)
16. SOCIAL SECURITY No:
17. INFORMANT'S ADDRESS: Box 370 Frostburg Md. Mrs Clement Lyons, R.D. No 1

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Coronary Occlusion
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic H.T. Disease
DUE TO (c) Advanced Arteriosclerosis Forage
420.1
Interval Between Onset And Death 1 wk.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. ,19 53, to Jan. 18 , 19 54, that I last saw the deceased alive on 1.18 , 1954, and that death occurred at 11:30 Am., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John B. Davis, M.D. Frostburg, Md 1/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-21-1954
NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.
LOCATION (City, town, or county) (State) R.F. Savage Md.
DATE REC'D BY LOCAL REGISTRAR 1-21-54
REGISTRAR'S SIGNATURE Mrs Nancy N. Poe
24. FUNERAL DIRECTOR Jacob Hafer
ADDRESS Frostburg, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie
LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Clyde (Middle) Alvin (Last) Cook

4. DATE OF DEATH: (Month) (Day) (Year) January 2, 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 19, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motorman

10b. KIND OF BUSINESS OR INDUSTRY: Street car man

11. BIRTHPLACE (State or foreign country): Bedford Co., Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Cook

14. MOTHER'S MAIDEN NAME: Rosetta Waugerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 172-18-1294

17. INFORMANT & ADDRESS: Mrs. Mae Cook, Ellerslie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Multiple Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1953, to Jan 2, 1954, that I last saw the deceased alive on Jan 2, 1954, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE John A Topper (DEGREE OR TITLE) MD ADDRESS Hyndman Pa DATE SIGNED Jan 3-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF January 5, 1954

NAME OF CEMETERY OR CREMATORY Pleasant Ridge

LOCATION (City, town, or county) (State) Buffalo Mills, Bedford Co Pa.

DATE REC'D BY LOCAL REG. Jan 4 1954

REGISTRAR'S SIGNATURE E Lloyd Wolfe

24. FUNERAL DIRECTOR ADDRESS Harvey H. Zeigler, Hyndman, Pa.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 110 GREENE STREET

3. NAME OF DECEASED: (Type or Print) (First) [redacted] (Middle) ANN (Last) CORRIGAN

4. DATE OF DEATH: (Month) JAN (Day) 13 (Year) 1954

5. SEX: F
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: 10/11/87
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housework
10b. KIND OF BUSINESS OR INDUSTRY: ~~NONE~~ Home
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL CORRIGAN
14. MOTHER'S MAIDEN NAME: EMMA NAHEAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

Immediate cause (a) Hypertensive Cardio Vascular

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Renal Disease

DUE TO (c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15-, 1941, to 1-13, 1954, that I last saw the deceased alive on 1-13, 1954, and that death occurred at 12 NOON, from the causes and on the date stated above.

SIGNATURE (Degree or title) W. L. Williams M.D. ADDRESS Cumberland DATE SIGNED 1-14-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/16/54
NAME OF CEMETERY OR CREMATORY St. Patricks Cem.
LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 14, 1954
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumb. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits

0097

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00014

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 8/24/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 420 Pine Place

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) W. (Last) Couthard

4. DATE OF DEATH: (Month) January (Day) 6, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 9/28/1867

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired - Coal Yard Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Couthard

14. MOTHER'S MAIDEN NAME: Nance Lyebarrger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 42.3:1 Pulmonary Hypostasis — Interval Between Onset And Death: 16 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Chronic Myocardial degeneration — ?

DUE TO

(c) General arteriosclerosis — ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952 to Jan. 6, 1954, that I last saw the deceased alive on Jan. 6, 1954 and that death occurred at 6:05 p.m., from the causes and on the date stated above.

SIGNATURE James E. McKeon (Degree or title) M.D. ADDRESS 49 Greene St. DATE SIGNED 1-7-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/8/54 — NAME OF CEMETERY OR CREMATORY Allegany County Cemetery, Cumberland, — LOCATION (City, town, or county) (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 7, 1954 — REGISTRAR'S SIGNATURE Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS H. Lee Silcox, Decatur St, Cumberland, Md.

VS. A15

JAN
BUREAU V. S.

File#3161 Item# 7 2/4/54 [illegible]

0073

00015

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing Rural — LENGTH OF STAY (in this place) 1 mo	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing-rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Mi. E. Lonaconing	STREET ADDRESS 4. mi. E. Lonaconing (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) George Edward (Middle) (Last) Crawford			4. DATE OF DEATH (Month) Jan. (Day) 15 (Year) 54 19		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Sept. 31 1870	9. AGE last birthday 83 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Barton, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Crawford		14. MOTHER'S MAIDEN NAME Fanny Lashbaugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No. —	17. INFORMANT AND ADDRESS Sherman Crawford, Lonaconing, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Hoover ~~[illegible]~~ Coronary Occlusion		1 d.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease		10 years
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan., 1952, to Jan. 15, 1954, that I last saw the deceased alive on 11 Jan., 1954, and that death occurred at 5:00 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	MD.	Lonaconing Md	1/16/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-19-54	NAME OF CEMETERY OR CREMATORY Philos Cem	LOCATION (City, town, or county) (State) esternport, Md.
DATE REC'D BY LOCAL REG. 1-19-54	REGISTRAR'S SIGNATURE Jeannette M Boal	24. FUNERAL DIRECTOR Ellsworth S. Boal, esternport, Md	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

V. S.

Write in corporate limits.

0008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00016

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland

LENGTH OF STAY (in this place) 35 Yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 329 Central Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland

STREET ADDRESS (If rural give location) 329 Central Ave

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) A (Last) Darr

4. DATE OF DEATH: (Month) January (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Unknown

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: First Federal Bank

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Da rr

14. MOTHER'S MAIDEN NAME: Ellen (Unknown)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-4160

17. INFORMANT & ADDRESS: Mrs Edward Darr 329 Central Ave

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X

Immediate cause (a) Carcinoma of Rectum

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death 2 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1954 to 1-1-, 1954, that I last saw the deceased alive on 12-30, 1953, and that death occurred at 1 P.M., from the causes and on the date stated above.

SIGNATURE J. J. Johnson (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED 1-4-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/4/54

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 4, 1954

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland Md.

RE
AN
BUREAU V. S.

Write in corporate limits

0009

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00017

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 79 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 215 Charles St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 215 Charles Street

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Elizabeth (Last) Deetz

4. DATE OF DEATH: (Month) Jan. (Day) 30 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	May, 26, 1874	80 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	West Virginia	U. S.

13. FATHER'S NAME: John Wright

14. MOTHER'S MAIDEN NAME: Rachel Traynor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	None	Olga E. Deetz 215 Charles St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) 42.0.0 Arteriosclerotic Heart Disease — Interval Between Onset And Death: 4 years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to Jan. 30, 1954, that I last saw the deceased alive on Jan 30, 1954, and that death occurred at 12:05 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ralph W. Ballis	M D	62 Grand St. Cumberland Md	1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/1/54	Hillcrest Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4 1954	Victor L. Lantz, M.D.	H. Lee Silcox	Cumberland, Md.

VS. A15

FEB
BUREAU V. S.

Outside of City Limits

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00018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland

LENGTH OF STAY (in this place) 8 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 Bowmans Addition

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Cumberland

STREET ADDRESS (If rural, give location) R.F.D.#3 Bowmans Addition

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) Elizabeth (Last) DeMoss

4. DATE OF DEATH (Month) Jan. (Day) 9 (Year) 19 54

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Unknown - 1881?

9. AGE last birthday: 72? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hancock, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Pryor

14. MOTHER'S MAIDEN NAME: ary Patele

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Bowmans Addition. Rt.3 Mrs. Elden J. Robb, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

450.0

Immediate cause (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH several yrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) (arthritis deformans)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 9-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan. 14, 1954

NAME OF CEMETERY, OR CREMATORY Rose Hill

LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Jan. 11, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

BUREAU V. S.

0059

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00019

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1 PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 74 Washington St.

3. NAME OF DECEASED: (Type or Print) (First) Clifford (Middle) (Last) Densmore
4. DATE OF DEATH: (Month) Jan. (Day) 11th, (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Feb. 26th, 1889	64 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Buffer-Robbin Stores	Celanese Corp.	Maryland	U.S.A.

13. FATHER'S NAME: David Densmore
14. MOTHER'S MAIDEN NAME: Virginia Stone

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes	W.War I	214-07-5906	Mrs. Laura Densmore, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
422.2 Immediate cause	(a) DUE TO Chronic Myocardial Insufficiency	2 years
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Pulmonary Fibrosis	2 years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4, 1954, to Jan 11, 1954, that I last saw the deceased alive on Jan 11, 1954, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. McLane MD Frostburg Md Jan 13 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 1-14-1954 | NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | LOCATION (City, town, or county) Frostburg | (State) Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 1-14-54 McNeely & Poe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

RECEIVED
JAN
BUREAU

DR. WEISMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00020

Reg. Dist. No. 4

0011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 19 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL, MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ACCIDENT
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARTHA (Middle) (Last) DURST

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 19 54

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: OCT. 3, 1876

9. AGE last birthday: 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CYRUS SPIKER

14. MOTHER'S MAIDEN NAME: DURST, Margaret

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Pneumonia, RLL	1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Pyelonephritis, right, due to yeast infection	3 weeks
	(c) DUE TO Diabetes mellitus	5 years ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe generalized arteriosclerosis — 7

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 11, 1954, to Jan 30, 1954, that I last saw the deceased alive on Jan 29, 1954, and that death occurred at 7:49 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H. Newman MD — 59 Greene St Cumberland Maryland — 1/30/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 1, 1954 — NAME OF CEMETERY OR CREMATORY: Durst Cemetery — LOCATION (City, town, or county) (State): Grantsville, Maryland

DATE REC'D BY LOCAL REGISTRAR: Jan. 30, 1954 — REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D. — **24. FUNERAL DIRECTOR** — ADDRESS: Wm Winterberg Grantsville Md

0060

00021

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing (rural); STREET ADDRESS (If rural, give location) Rural near Lonaconing

3. NAME OF DECEASED (Type or Print): (First) Lenord; (Middle); (Last) Dye

4. DATE OF DEATH: (Month) January; (Day) 9; (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 31, 1893

9. AGE last birthday: 55 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Band Wrapper Kelly Tire Co.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Dye

14. MOTHER'S MAIDEN NAME: Susan Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-05-2909

17. INFORMANT: Helen Dye (Wife) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X

Immediate cause (a) Chronic myocarditis with heart failure — Interval Between Onset and Death: 2 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Bronchial asthma — 5 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/10, 1953, to 1/9, 1954, that I last saw the deceased alive on 1/8, 1954, and that death occurred at 220 p.m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walton (Degree or title) M.D. ADDRESS Frostburg Md DATE SIGNED 1/9/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 12, 1954

NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park.

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 1-11-54

REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rae

24. FUNERAL DIRECTOR ADDRESS: George Eichhorn, Lonaconing, Md.

VS. A15

RECEIVED
JAN 15 1
BUREAU V. S.

Within corporate limits

00022

0012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland — LENGTH OF STAY (In this place) 21 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS D.O.A. At the Memorial Hospital 112 Altamont Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 112 Altamont Terrace

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Peter	T.	Ervin	Jan.	9	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	Feb. 2-1889	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Clerk to Trainmaster	B&O.R.Ry.	Dennison, Ohio	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Charles A. Ervin	Retta Mattern

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO:	17. INFORMANT & ADDRESS:
no	705-05-8130	(wife) Mrs. P. Ervin, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Coronary occlusion	sudden
DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	Coronary sclerosis	?
	(c)		

420.1

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H. V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 9-1951

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 12, 1954	Queen's Point Cem	Keyser, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 12, 1954	Winter L. Hauk, M.D.	John J. Zafer	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

Within corporate limits

0013

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00023

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
STREET ADDRESS (If rural give location) 406 VIRGINIA AVENUE

3. NAME OF DECEASED: (Type or Print) (First) HOWARD (Middle) J. (Last) FELTON

4. DATE OF DEATH: (Month) JAN. (Day) 31 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRRIED

8. DATE OF BIRTH: APR. 19, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER-B & O

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ZACHARIAH FELTON

14. MOTHER'S MAIDEN NAME: MARY JANE TANNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No ~~UNK~~ (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-07-6782

17. INFORMANT & ADDRESS: MEMORIAL HOSPTTAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Tuberculous Pneumonia — Interval Between Onset And Death 5 wks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: U

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 20, 1953, to Jan. 31, 1954, that I last saw the deceased alive on Jan. 31, 1954, and that death occurred at 11:50 P.M. from the causes and on the date stated above.

SIGNATURE Clay R. Durrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED Feb. 1, 1954.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2/3/54 NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 1, 1954 REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1934
BUREAU V[illegible]

Within corporate limit. 0014

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00024

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 2
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 2
STREET ADDRESS (If rural give location) 739 Washington St.

3. NAME OF DECEASED: (Type or Print) (First) Grace (Middle) May (Last) Fisher

4. DATE OF DEATH: (Month) Jan. (Day) 15, (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 30, 1887
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Operated Theatres
10b. KIND OF BUSINESS OR INDUSTRY: Own Theatres
11. BIRTHPLACE (State or foreign country): Russell, Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles E. McKnight
14. MOTHER'S MAIDEN NAME: Laura C. Colden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Miss. Vivian Fisher Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
331X Immediate cause	(a) [redacted] pneumonia, terminal	4 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Right hemiplegia due to hemorrhage of brain	5 "
	DUE TO (c) Arteriosclerosis, general, severe	6 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Coronary disease 6 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, to Jan 15, 1954, that I last saw the deceased alive on Jan 15, 1954, and that death occurred at 4:25 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Isabelle G. Weisman MD
ADDRESS 59 Greene St Cumberland, Md
DATE SIGNED 1/17/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-18-1954
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan 18, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR CHARLES L. GEORGE
ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The Error age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 20 1954
BUREAU V. S.

0015 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00025

CERTIFICATE OF DEATH

DR. HODGES

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 2 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE NEW YORK COUNTY Manhattan
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW YORK CITY, N.Y.
STREET ADDRESS (If rural give location) 14 W. 29TH STREET ✓

3. NAME OF DECEASED: (Type or Print) Dorothy (First) Eloise (Middle) (Last) ~~BABY~~ ~~GIRL~~ FITTAPALDI

4. DATE OF DEATH: (Month) (Day) (Year) JANUARY 30, 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: JANUARY 29, 1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 2 Min. 2

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH P. FITTAPALDI
14. MOTHER'S MAIDEN NAME: JANE A. SMITH

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0

Immediate cause (a) atelectasis?

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death 1 1/2 hrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Marked sternal retraction.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-29, 1954, to 1-30, 1954, that I last saw the deceased alive on 1-29, 1954, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W Royce Hodges, M. D. ADDRESS Cumberland, Md DATE SIGNED 1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF I-31-54
NAME OF CEMETERY OR CREMATORY Olivet Cem.
LOCATION (City, town, or county) (State) Kessel, W.Va.

DATE REC'D BY LOCAL REGISTRAR Jan. 30, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

FEB
BUREAU V. S.

Within corporate limits

0016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00026

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia COUNTY Mineral
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley
STREET ADDRESS (If rural give location) Carpenter's Addition ✓

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) (Last) FLANAGAN
4. DATE OF DEATH: (Month) JANUARY (Day) 23, (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Jan. 23, 1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 1 Min. 35

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stewart Ollie Flanagan
14. MOTHER'S MAIDEN NAME: Gladys Evelyn Valentine

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Sacred Heart Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

773.5

Immediate cause (a) Failure of Respiratory & Cardiac Function

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) due to undeveloped Vital organs

DUE TO

(c) (Previable Premature)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 23, 19 54 to Jan. 23, 1954, that I last saw the deceased alive on Jan. 23, 19 54, and that death occurred at 3:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Leland A. Causom MD ADDRESS 63 Greene St., Cumberland, Md. DATE SIGNED Jan. 24 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 24, 1954
NAME OF CEMETERY OR CREMATORY Pope Cemetery
LOCATION (City, town, or county) (State) Wiley Ford, West Virginia.

DATE REC'D BY LOCAL REGISTRAR Jan. 24, 1954
REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc., Cumberland, Maryland. ADDRESS

RECEIVED
FEB
BUREAU V. S.

0067

00027
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 14 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS In his garage. 219 Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 219 Green St.

3. NAME OF DECEASED: (Type or Print) (First) Osborne (Middle) Leghora (Last) Flick

4. DATE OF DEATH (Month) Jan. (Day) 12 (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 16 1910

9. AGE Last birthday: 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carander worker for

10b. KIND OF BUSINESS OR INDUSTRY: W.Va.Pulp & Paper Co.

11. BIRTHPLACE (State or foreign country): Barnum, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard Flick

14. MOTHER'S MAIDEN NAME: Harriett Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 236-03-2594

17. INFORMANT & ADDRESS: (wife) Mildred Chashire Flick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

9/6 X

Immediate cause (a) Intra-abdominal hemorrhage due to a 12 gauge — sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) shotgun wound in abdomen, just below sternum,

DUE TO

(c) self inflicted.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) garage

21c. (City or town) Westernport (County) Allegany (State) Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 12/54 about 2.30 P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Shot himself with a 12 gauge shotgun in abdomen.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M. D.

M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED Jan. 12-1954

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 1-15-54

REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00028

CERTIFICATE OF DEATH

Reg. Dist. No. 4

0017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
LENGTH OF STAY (in this place) 43 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 336 Virginia Ave.

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 336 Virginia Ave.

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Joseph (Last) Foley
4. DATE OF DEATH: (Month) January (Day) 18, (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Single	April 27, 1903	50 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Machinist	Railroad	Westernport, Md.	U.S.A.

13. FATHER'S NAME: William P. Foley
14. MOTHER'S MAIDEN NAME: Ellen Hoban

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No.			John J. Foley, Prince George St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bilateral Pulmonary Tuberculosis — Interval Between Onset And Death: 6 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐	Not While At Work ☐	HOW DID INJURY OCCUR?
m.			

22. I hereby certify that I attended the deceased from Jan. 14, 1954, to Jan. 18, 1954, that I last saw the deceased alive on Jan. 14, 1954 and that death occurred at 3:30 a.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Cloyd L. Durrett	M.D	Cumberland.	1/19/54.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-20-54	St. Mary's Cem	Cumberland, Md.

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 19, 1954	Wesley K. Kantz, M.D.	James F. Scarpelli,	Cumberland, Md.

VS. A15

RECEIVED
JAN 28 19[illegible]
BUREAU V. S.

Outside City Limits

0018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 0129

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Cumberland

LENGTH OF STAY (in this place) 37 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. #4 Christie Road.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (rural) Cumberland

STREET ADDRESS (If rural, give location) R.F.D. # 4 Christie Road

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Emily	Virginia	Free	Jan.	9	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widow	Dec. 1-1872	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Cumberland, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Henry Kuhn	Mary Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	None	(daughter) Elizabeth Free

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
442X Immediate cause	(a)	Acute cardiac failure	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Cardio-vascular-renal disease	?
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 9-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 13 1954	Hegenmount Cem.	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 11, 1954	Walter R. Franz, M.D.	James L. Scarpelli	" "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type or print age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

NUMEAU V. S

Within corporate limits

0019

MARYLAND

00030

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

1

1. PLACE OF DEATH COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md. LENGTH OF STAY (in this place) 35yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 133 Arch St.	STREET ADDRESS (If rural, give location) 133 Arch St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Sue Evelyn Gaebl	4. DATE OF DEATH (Month) (Day) (Year) 1-13-54 19
5. SEX F / 6. COLOR OR RACE W / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 12, 1895 / 9. AGE last birthday 58 yrs. If under 1 year Months Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife / 10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Westernport, Md. / 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles E. Drenning	14. MOTHER'S MAIDEN NAME Margaret L. Brady
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) / 16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Miss Aurelia V. Drenning 133 Arch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

410X Immediate cause (a) Myocardial infarction — 1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic cardiovascular disease with mitral stenosis — 40 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1951, to Jan 13, 1954, that I last saw the deceased alive on Jan 12, 1954, and that death occurred at 10 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[illegible] Ralph Lock, M.D. 20 [illegible] Cumberland, Md 1/14/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE I-16-54	NAME OF CEMETERY OR CREMATORY St Mary's Cem	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Jan. 15, 1954	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR James F. Scarpelli	ADDRESS Cumberland, Md.

Film#G160 Item# 14 1/13/54 emp

00031
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 5

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Danville
LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 Keyser, W.Va.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (rural) Danville
STREET ADDRESS (If rural, give location) R.F.D.#3 Keyser, W.Va.

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) Elizabeth (Last) Guthrie

4. DATE OF DEATH (Month) Jan. (Day) 5 (Year) 19 54

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH: Feb. 28, 1887

9. AGE last birthday: 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elk Garden, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Dixon

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: (son) Jackson Gutherie, Danville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause 442X (a) Acute Cardiac Failure — Interval Between Onset and Death: Sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Cardio Vascular Renal Disease — Interval Between Onset and Death: ?

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan.5-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan 9-53

NAME OF CEMETERY OR CREMATORY Wasler

LOCATION (City, town, or county) Dawson (State) Md.

DATE REC'D BY LOCAL REG. 1/7-54

REGISTRAR'S SIGNATURE M. L. Ramsburg

24. FUNERAL DIRECTOR ADDRESS Rogers Funeral Home, Keyser W.Va.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - ■ - 53

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 N. Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 413 N Centre St

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Thomas (Last) Hager.

4. DATE OF DEATH: (Month) Jan (Day) 18 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 1872

9. AGE last Birthday: 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Self. stone work.

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James M. Hager

14. MOTHER'S MAIDEN NAME: Rebecca J. Street

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-16-2033

17. INFORMANT & ADDRESS: Mrs. Walter Thomas Hager.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 X
Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 8 hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertensive Heart — Some years
DUE TO (c) Senility 83 years old

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) no — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 8, 1954, to Jan 18 1954 that I last saw the deceased alive on Jan 17 1954, and that death occurred at 6:15 a.m., Jan 18-54, from the causes and on the date stated above.

SIGNATURE (Degree or title) Alan G. Murray M.D. — ADDRESS Cumberland Md — DATE SIGNED Jan 18 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan. 20 1954 — NAME OF CEMETERY OR CREMATORY Rosemount Cem. — LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 19, 1954 — REGISTRAR'S SIGNATURE Walter K. Kantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc — ADDRESS Cumberland

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10

0075

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Alleg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage
STREET ADDRESS (If rural give location) Main Street.

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Franklin (Last) Hergott

4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 31-~~1882~~ 1881
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist
10b. KIND OF BUSINESS OR INDUSTRY: railroad shop
11. BIRTHPLACE (State or foreign country): Mt. Savage
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Francis Hergott
14. MOTHER'S MAIDEN NAME: Laura Beaver

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs BarbaraHergott

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) CORONARY OCCLUSION — Interval Between Onset And Death: FEW MINUTES

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) VASCULAR HYPERTENSION — SEVERAL YEARS

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTESTINAL FLATULENCE

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1945 to January 1954, that I last saw the deceased alive on 1-1, 1954, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE William E. Moseley (Degree or title) M.D. ADDRESS Mt Savage, Md. DATE SIGNED January 4th 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 5-1954
NAME OF CEMETERY OR CREMATORY St. George
LOCATION (City, town, or county) (State) Mt. Savage, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 4-54
REGISTRAR'S SIGNATURE Veronica McDermott

24. FUNERAL DIRECTOR J.R. Durst. ADDRESS Frostburg, Md.

JAN 3
BUREAU V. E

Within corporate limits

0021

Dr. Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00034

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 227 Paca St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,

STREET ADDRESS (If rural give location) 227 Paca St.,

3. NAME OF DECEASED: (Type or Print) (First) CARRIL (Middle) L. (Last) HEXT

4. DATE OF DEATH: (Month) Jan. (Day) 12, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Feb. 23, 1877

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired). Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Hext

14. MOTHER'S MAIDEN NAME: Mary Curley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Charles A. Ritter 227 Paca St., Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X

Immediate cause (a) Cerebral Apoplexy — Interval Between Onset And Death: 3 mos.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension — 7 days

DUE TO

(c) — 2 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 6, 1953, to Jan. 12, 1954, that I last saw the deceased alive on Jan. 12, 1954, and that death occurred at 11:29 P.M., from the causes and on the date stated above.

SIGNATURE C. Zimmerman (M.D.) (Degree or title) ADDRESS 105 S. Centre St. DATE SIGNED 1-14-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/15/54

NAME OF CEMETERY OR CREMATORY St. Lukes Cem.

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 14, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumb rland, Md.

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BUREAU V. S.

Within corporate limits

0022

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 C0335

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 34 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 715 Lincoln St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

STREET ADDRESS (If rural, give location): 715 Lincoln St.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) RAYMOND (Last) HINKLE

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 17, 1954 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 6, 1888

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Building houses

11. BIRTHPLACE (State or foreign country): Allegany Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Summerfield Hinkle

14. MOTHER'S MAIDEN NAME: Rhoda Wolford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218 30 0568

17. INFORMANT & ADDRESS: Mrs. Leah Hinkle, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause (a) DUE TO: Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO:

(c) Essential Hypotension

INTERVAL BETWEEN ONSET AND DEATH: from 5-25-53

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-16-, 1953, to 1-17-, 1954, that I last saw the deceased alive on 1-16-, 1954, and that death occurred at 3 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS: M. F. Williams M.D. Cumberland — DATE SIGNED: 1-18-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1/19/1954

NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Jan. 19, 1954

REGISTRAR'S SIGNATURE: Walter K. Fantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

Within corporate limits

0023

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00036

CERTIFICATE OF DEATH

DR. W.F. WILLIAMS

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 30 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLE.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
STREET ADDRESS (If rural give location) 225 GRAND AVENUE

3. NAME OF DECEASED: (Type or Print) (First) MARGUERITE (Middle) C. (Last) HOUT

4. DATE OF DEATH: (Month) JAN. (Day) 11 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: APRIL 9, 1900

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES C. CROGAN

14. MOTHER'S MAIDEN NAME: MARY MARTHA SPICER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

Immediate cause (a) Metastatic Carcinoma

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death: July '52 to death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 52

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of breast

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 1953, to 1-11-, 1954, that I last saw the deceased alive on 1-11-, 1954, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W.F. Williams M.D.

ADDRESS Cumberland

DATE SIGNED 1-12-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan. 14, 1954

NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR: Jan. 13, 1954

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli

ADDRESS: Cumberland, "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

0024 by Cooper

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 C0537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 59 Minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown, Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Baby Girl (Middle) (Last) Jones

4. DATE OF DEATH: (Month) Jan. (Day) 1 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 1, 1954

9. AGE Last birthday: No yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min. 59

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard D. Jones

14. MOTHER'S MAIDEN NAME: Betty Lou Ware

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Richard Jones, Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

761.5
Immediate cause (a) Prematurity - acelectasis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Premature Separation Placenta — 24-days
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan, 1954, to 1 Jan, 1954, that I last saw the deceased alive on 1 Jan, 1954, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE L. Slocum (Degree or title) M.D. — ADDRESS 101 S. Centre St. Cumberland — DATE SIGNED 1-1-54 (State)

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan. 2, 954 — NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery — LOCATION (City, town, or county) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan 2, 1954 — REGISTRAR'S SIGNATURE Walter R. Manly M.D. — ADDRESS

24. FUNERAL DIRECTOR Charles L. George, Cumberland, Md.

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BUREAU V. S.

Within corporate limits

0025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06038

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 508 Park St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,
STREET ADDRESS (If rural give location) 508 Park St.,

3. NAME OF DECEASED: (Type or Print) (First) CLYDE (Middle) BLUFORD (Last) KELLER

4. DATE OF DEATH: (Month) Jan. (Day) 28, (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan. 20, 1891
9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired car inspector
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.
11. BIRTHPLACE (State or foreign country): Hinton, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William H. Keller
14. MOTHER'S MAIDEN NAME: Emma Freeland

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 705-05-5493
17. INFORMANT & ADDRESS: Mr. Carl A. Keller 508 Park St., Cumb. Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

227X

Immediate cause (a) Metastasis from extradual

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) spinal cord tumor of un-

DUE TO

(c) determined origin

Interval Between Onset And Death: Since Sept. 48

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. + infiltrated the dura + spinal cord

19a. DATE OF OPERATION: 1-12-50
19b. MAJOR FINDINGS OF OPERATION Large infiltrating tumor found which had eroded Vertebra T12

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948, to 1-28, 1954, that I last saw the deceased alive on 1-3-, 1954 and that death occurred at 9:15 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) W. L. Williams MD. ADDRESS Cumberland DATE SIGNED 1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/31/54
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 30, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00039

DR. WHITWORTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 18 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, Rural
STREET ADDRESS (If rural give location) ROUTE #6

3. NAME OF DECEASED: (Type or Print) (First) BARBARA (Middle) ANN (Last) KING
4. DATE OF DEATH: (Month) JANUARY (Day) 27, (Year) 1954
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: DEC. 9, 1953
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months 1 Days 18 IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CLYDE EDWARD KING
14. MOTHER'S MAIDEN NAME: RUTH IRENE WOOD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

751X

Immediate cause (a) Hydro-Cephalus DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Spina-Bifidus DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 9, 1953, to JAN. 27, 1954, that I last saw the deceased alive on JAN. 27, 1954, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

SIGNATURE Fuller B. Whitworth (Degree or title) MD ADDRESS 123 Bed Pl. DATE SIGNED 28 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Jan 28-1954
NAME OF CEMETERY OR CREMATORY Oakland Cemetery
LOCATION (City, town, or county) Oakland (State) Md
DATE REC'D BY LOCAL REGISTRAR Jan 28, 1954
REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.
24. FUNERAL DIRECTOR Emroy Boldin ADDRESS Oakland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): 123 S. Water Street

3. NAME OF DECEASED: (Type or Print) (First) AMY (Middle) (COOPER) (Last) KNEPP

4. DATE OF DEATH: (Month) Jan. (Day) 23, (Year) 19 54

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH: 7-29-1903

9. AGE last birthday: 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Cooper

14. MOTHER'S MAIDEN NAME: Emily Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-20-5463

17. INFORMANT & ADDRESS: Mrs. Beatrice Laporta, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

197X
Immediate cause — (a) Metastatic Carcinoma both lungs — Interval Between Onset And Death: 6 months

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Fibromyosarcoma — 2 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20, 19 50, to Jan. 23, 19 54, that I last saw the deceased alive on Jan 23, 19 54, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, M.D. — ADDRESS: Frostburg, Md — DATE SIGNED: 1/23/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-26-54 — NAME OF CEMETERY OR CREMATORY: F'burg. Memorial Park — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-26-54 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

0062

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 9041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg

LENGTH OF STAY (in this place) 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Ohio — COUNTY Cuyahoga

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cleveland

STREET ADDRESS (If rural, give location) 5414 Detroit Ave. ✓

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
(Type or Print) Howard R. Lancaster	Jan. 30 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	single	Nov. 26-1934	19 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber Helper	Rudd Heating Co.	Frostburg, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Roy Wolford Lancaster	Helen Winfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
	220-32-2545	(mother) Mrs. Helen Lancaster, Cleveland, Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Respiratory failure due to shock, hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) and anesthesia, during tonsilectomy.	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Enlarged thymus & congestive viscera

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
Jan. 30-1954	Infected & enlarged tonsils	Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21c. (City or town) (County)	(State)
	Miners Hospital,	Frostburg Allegany	Md.

21d. TIME OF INJURY (Month, Day, Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
Jan. 30/54 A. M. 11:20		Under surgery and an anesthetic - Tonsilectomy

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE	M. D.	CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.			Jan. 30-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-2-1954	Eckhart Cemetery	Eckhart, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-1-54	Mrs. Nancy H. Poe	Jacob Hafer,	Frostburg, Md.

VS. A15A - 5 - 53

BUREAU V. S.

0063

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00042

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 109 Maple St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) 109 Maple St.

3. NAME OF DECEASED: (Type or Print) (First) ELWOOD (Middle) E. (Last) LARUE

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH: 7-15-1864

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Garrett County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Larue

14. MOTHER'S MAIDEN NAME: Rebecca Durst

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs. Wm. Buckalew, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 x

Immediate cause (a) Arterio-Sclerosis — Interval Between Onset And Death ??

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chr Nephritis — ??

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 12, 1954, to Jan 18, 1954, that I last saw the deceased alive on Jan 12, 1954, and that death occurred at 9:45 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) W. M. Lane M.D. ADDRESS Frostburg Md DATE SIGNED Jan 20 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1-21-54 NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery LOCATION (City, town, or county) (State) Garrett County, Md.

DATE REC'D BY LOCAL REGISTRAR 1-21-54 REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

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JAN 2
BUREAU V. S.

Within corporate limits

0027

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00043

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland — LENGTH OF STAY (in this place) 11/23/53	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural give location) 447 Goethe Street

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) T. (Last) Loy

4. DATE OF DEATH: (Month) January (Day) 24 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow	12/13/1882	71 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Lonaconing, Maryland	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Adam Thompson	Helender Spears

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No		None	Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

		Interval Between Onset And Death
Immediate cause	(a) Cerebral Hemorrhage	14 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cerebral arteriosclerosis	?
	DUE TO (c) Diabetes Mellitus	13 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension ?

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 23, 1953 to Jan. 24, 1954, that I last saw the deceased alive on Jan. 23, 1954, and that death occurred at 1.15 p.m., from the causes and on the date stated above.

SIGNATURE James G. McCleary (Degree or title) M.D. ADDRESS 49 Greene St. DATE SIGNED 1-25-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 27 1954	St. Lukes Cemetery	Cumberland, Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 26, 1954	Winter R. Frantz, M.D.	William H. Kight, Cumberlnad, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 45, Vocke Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Cumberland

STREET ADDRESS (If rural, give location) Route 45, Vocke Drive

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth, (Middle) Marley (Last) Martz

4. DATE OF DEATH (Month) Jan. (Day) 11 (Year) 1954

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Sept. 17-1872

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Sandy Hook, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Marley

14. MOTHER'S MAIDEN NAME: Mary House

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: (son) George Martz, Cumberland, Md. Rt. 5

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2

Immediate cause (a) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Chronic myocarditis — several years.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 11-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan. 13, 1954

NAME OF CEMETERY OR CREMATORY St. Peters and Pauls Cem

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Jan. 12, 1954

REGISTRAR'S SIGNATURE M. [illegible]

24. FUNERAL DIRECTOR Charles L. George, " ADDRESS "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C0045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 13 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE West Virginia — COUNTY Monongalia
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeley
STREET ADDRESS (If rural give location) Md. Junction

3. NAME OF DECEASED: (Type or Print) (First) Patricia (Middle) Jane (Last) McFadden

4. DATE OF DEATH: (Month) Jan. (Day) 18, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-30-1946

9. AGE last birthday: 7 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: J. William McFadden

14. MOTHER'S MAIDEN NAME: Betty Jane Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: J. William McFadden Ridgeley, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Rheumatic Heart Disease — Interval Between Onset And Death: 3 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Rheumatic Fever — 3 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-16, 1953, to 1-18, 1954, that I last saw the deceased alive on 1-18., 1954., and that death occurred at 3:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Ralph W. Breene M.D. — 62 Greene St. Cumberland Md — 1-21-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-21-1954 — NAME OF CEMETERY OR CREMATORY: HillCrest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 21, 1954 — REGISTRAR'S SIGNATURE: Walter K. Nash, M.D. — 24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00046

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 3 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 233 Centre St.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) A. (Last) Middleton
4. DATE OF DEATH: (Month) 1 (Day) 14 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 5-10-1883
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Brick Setter
10b. KIND OF BUSINESS OR INDUSTRY: Brick Yard
11. BIRTHPLACE (State or foreign country): Barrellsville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Middleton
14. MOTHER'S MAIDEN NAME: Marie Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ? (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Frostburg, Md. Alonzo Middleton, 233 Centre St.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset And Death: 1 wk

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral Arteriosclerosis

DUE TO

(c) Hypertension

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PARKINSONISM

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/9, 1954, to 1/14, 1954, that I last saw the deceased alive on 1/13, 1954, and that death occurred at 7 AM, from the causes and on the date stated above.

SIGNATURE John C. Devers (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED 1/14/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-16-1954
NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-16-54
REGISTRAR'S SIGNATURE Mrs Nancy N Roe
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00047

Reg. Dist. No. 4

M 0030

1. PLACE OF DEATH:
COUNTY ALLEGHANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 42 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Garrett
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~BOX 101~~ BLOOMINGTON
STREET ADDRESS (If rural give location) Box 101 ✓

3. NAME OF DECEASED: (Type or Print) (First) Christina (Middle) Pearl (Last) MORTON

4. DATE OF DEATH: (Month) JANUARY (Day) 9, (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH: FEBRUARY 11, 1914
9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Machine Operator HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES SMILEY
14. MOTHER'S MAIDEN NAME: MAGGIE BARNARD

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 215-20-5170
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 171X (a) Carcinoma of Cervix — Interval Between Onset And Death: About 2 yr

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Uremia

DUE TO

(c) Bilat. carcinomatous obstruction of ureters — 3 mo

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 28, 1953, to Jan 9, 1954, that I last saw the deceased alive on Jan 8, 1954, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Mirkin MD ADDRESS Cumberland Md. DATE SIGNED 1-10-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 12, 1954
NAME OF CEMETERY OR CREMATORY Bloomington Cemetery
LOCATION (City, town, or county) (State) Bloomington, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 11, 1954
REGISTRAR'S SIGNATURE Winter R. Frank, M.D.
24. FUNERAL DIRECTOR E. S. Base ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00048

Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing ×
LENGTH OF STAY (in this place) 90 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS (If rural give location) Railroad Street

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) J. (Last) Muir

4. DATE OF DEATH: (Month) Jan, (Day) 3 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: May, 7. 1863
9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine
11. BIRTHPLACE (State or foreign country): Lonaconing, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hugh Muir
14. MOTHER'S MAIDEN NAME: Annie Hunter

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mr. James Muir, Lonaconing, Md. (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 442 X (a) Chr. Cardio-Vascular-renal DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Disease DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/1, 1953, to 1/3, 1954, that I last saw the deceased alive on 1/1, 1954, and that death occurred at 11 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] MD
ADDRESS [signature]
DATE SIGNED 1/4/53

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial
DATE THEREOF Jan. 5 1954
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) (State) Lonaconing, Md.

DATE REC'D BY LOCAL REGISTRAR Jan 5, 1954
REGISTRAR'S SIGNATURE Jannette M. Boal
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md
ADDRESS

JAN 5 19
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00049

CERTIFICATE OF DEATH

DR. A. JONES

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERRLAND
STREET ADDRESS (If rural give location): 106 E. THIRD STREET

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) P. (Last) MUNDAY

4. DATE OF DEATH: (Month) JANUARY (Day) 29, (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	WIDOWED	SEPT. 12, 1871	82 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life.	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Last Work was Laborer	Railroad	WEST VIRGINIA Morgan County	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Patrick MUNDAY	Martha Easton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

32 X

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset And Death: 12 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General Arteriosclerosis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-28, 19 54, to 1-29, 19 54, that I last saw the deceased alive on 1-28, 19 54, and that death occurred at 12:05 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Arthur P. Jones M.D.	63 Greene St.	1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-31-54	Greenway Cem	Berkley Spring, W.Va.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 30, 1954	Winter K. Kantz, M.D.	James F. Scarpelli	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

FEB

003

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4250

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 19days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wellersburg 75 x -3
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Louis (Middle) Daniel (Last) Neubeiser

4. DATE OF DEATH: (Month) (Day) (Year) January 6, 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Sept. 28, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Brewery

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Neubeiser

14. MOTHER'S MAIDEN NAME: Anna Kehneriman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213 09 6431

17. INFORMANT & ADDRESS: Mrs Louis Neubeiser Wellersburg, Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) 162X Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 7 mos

DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-23, 19.53, to 1-6, 19.54, that I last saw the deceased alive on 1-6, 19.54, and that death occurred at 7:50 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Ralph L. Bacani M.D. 62 Greene St. Cumberland Md 1-8-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 9, 1954 — NAME OF CEMETERY OR CREMATORY: Wellersburg Cemetery — LOCATION (City, town, or county) (State): Wellersburg, Pa.

DATE REC'D BY LOCAL REG. Jan. 8, 1954 — REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Harvey H. Zeigler, Hyndman, Pa.

VS. A15 8-51

RECEIVED
MAY
BUREAU V. S.

Within corporate limits

0033

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 51

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (in this place) 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Savage

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) P. (Last) Noonan

4. DATE OF DEATH (Month) Jan. (Day) 14 (Year) 19 54

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: May 1-1886

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired laborer

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Mt Savage, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Noonan

14. MOTHER'S MAIDEN NAME: Helen Dunningham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-07-6230

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

9285

Immediate cause (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Intertronchanteric fracture of right femur — 2 days

DUE TO

(c) a fall on icy pavement.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sidewalk

21c. (City or town) Cumberland (County) Allegany (State) Md.

21d. TIME OF INJURY (Month) Jan. (Day) 12/54 (Year) (Hour) about 3.30 A. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Slipped & fell on icy sidewalk & fractured right femur.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 14-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan. 16, 1954

NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery

LOCATION (City, town, or county) Mt. Savage, Maryland (State)

DATE REC'D BY LOCAL REG. Jan. 15, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Joseph R. Hurst, Frostburg

ADDRESS "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00652

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 60 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 333 Baltimore Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 333 Baltimore Ave

3. NAME OF DECEASED: (Type or Print) (First) Miranda (Middle) Susan (Last) Nuse

4. DATE OF DEATH: (Month) January (Day) 17 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 19 1873

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Allegany Co, Maryland.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: David V. Twigg

14. MOTHER'S MAIDEN NAME: Mulvina Deffenbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Walter Weires, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) Bronchopneumonia — DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) DUE TO

(c) Acute Myocardial Degeneration

INTERVAL BETWEEN ONSET AND DEATH: 1 week

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-21, 1948 to 1-17, 1954 that I last saw the deceased alive on 1-17-54, 1954 and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) (ADDRESS) — DATE SIGNED

M. F. Williams M.D. Cumberland 1-18-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan 20 1954

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: Jan. 19, 1954

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight

ADDRESS: Cumberland, Md.

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Within corporate limits

0053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SYLVAN RETREAT M

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG
STREET ADDRESS (If rural, give location) 75 E. MAIN ST.

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) G. (Last) PATRICK

4. DATE OF DEATH: (Month) 1 (Day) 12 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 6-15-1893

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Patrick

14. MOTHER'S MAIDEN NAME: Isabel Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes ✓ (If Yes, give war or dates of service) W.War 1

16. SOCIAL SECURITY NO.: 232-26-4316

17. INFORMANT & ADDRESS: Mrs. John Zais, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 293x

			Interval Between Onset and Death
Immediate cause	(a)	Chronic Myocardial Degeneration	?
Antecedent cause(s)	DUE TO (b)	Gastric Hemorrhage	?
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (c)	Secondary Anemia	?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Dementia praecox — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 9, 1954, to Jan. 11, 1954, that I last saw the deceased alive on Jan. 11, 1954, and that death occurred at 6.30 a.m., from the causes and on the date stated above.

SIGNATURE James E. McCrea (DEGREE OR TITLE) M.D. ADDRESS 49 Green St. DATE SIGNED 1-12-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 1-15-1954

NAME OF CEMETERY OR CREMATORY Philos Cemetery

LOCATION (City, town, or county) (State) Westernport, Md.

DATE REC'D BY LOCAL REG. Jan 14, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Joseph R. Durst, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00054

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westernport
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Stoney Run Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Stoney Run Road

3. NAME OF DECEASED: (Type or Print) (First) [illegible]RY (Middle) [illegible]ZA (Last) PLASZ

4. DATE OF DEATH: (Month) Jan (Day) 5 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): [illegible]arried

8. DATE OF BIRTH: Feb 17, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]atron

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]elland Engr Co

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Soyak

14. MOTHER'S MAIDEN NAME: [illegible]ary Soyak

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Stephen Plosz, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) Cerebral Hemorrhage — DUE TO — Interval Between Onset and Death: 6 Hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Arteriosclerosis and Hypertension — DUE TO — 2 Years

(c)

331 X

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) None — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1954, to Jan 5, 1954, that I last saw the deceased alive on Jan 5, 1954, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Paul A Wilson M.D. Piedmont, W. Va. Jan. 6, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF 7 Jan '54 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State) Lorain, Lorain Co., Ohio

DATE REC'D BY LOCAL REG. Jan 7, 1954 — REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR ADDRESS E. S. Boal, Westernport, Maryland

RECEIVED
JAN 11 1954
BUREAU V. S.

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

DR. REITER

Reg. Dist. No. 4

0038

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: ALLEGANY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
LENGTH OF STAY (in this place): 89 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND — COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
STREET ADDRESS (If rural give location): 317 COLUMBIA STREET

3. NAME OF DECEASED: (Type or Print) (First) CHRISTOPHER (Middle) MARTIN (Last) PRICE

4. DATE OF DEATH: (Month) JANUARY (Day) 31, (Year) 19 54

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: APRIL 26, 1953

9. AGE last birthday: yrs. 0 — IF UNDER 1 YEAR: Months — Days 5 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM PRICE

14. MOTHER'S MAIDEN NAME: EFFIE M. RYAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 340.0 (a) DUE TO Hemophilus Influenza Type A. Meningitis — Interval Between Onset And Death: 2 mo.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydrocephalus — since birth

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 2, 1953, to Jan 31, 19 54, that I last saw the deceased alive on Jan 30, 1954, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

SIGNATURE: Ralph A. Reiter (Degree or title) M.D. — ADDRESS: 112 Bedford St — DATE SIGNED: Feb 2, 1954

23. BURIAL, CREMATION, REMOVAL: (Specify) Burial — DATE THEREOF: Feb. 2, 1954 — NAME OF CEMETERY OR CREMATORY: Zion Memorial Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 2, 1954 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md. — ADDRESS

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VS. A15

BUREAU V. S.

Within corporate limits

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DR. W.F.WMS. SURNAME: film G161 2-9-54 LL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CC056

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAN D

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNSYLVANIA COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MEYERSDALE
STREET ADDRESS (If rural give location) 116 MARKET STREET

3. NAME OF DECEASED: (First) MAE (Middle) A. Carolina (Last) PANACCIATI [redacted]
4. DATE OF DEATH: (Month) JANUARY (Day) 14 (Year) 1954
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: JAN. 6, 1918
9. AGE last birthday: 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Making Shirts
10b. KIND OF BUSINESS OR INDUSTRY: Meyersdale Mfg. Co.
11. BIRTHPLACE (State or foreign country): Meyersdale, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CARMAN A. PANACCIATI [redacted]
14. MOTHER'S MAIDEN NAME: Carolina ANNA E. GREIG
15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 194-03-0063
17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

410 X Immediate cause (a) Chronic Rheumatic Heart
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Dis. (Mitral Stenosis)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Virus Pneumonia

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-8-, 1954, to 1-14, 1954 that I last saw the deceased alive on 1-14, 1954 and that death occurred at 11:10 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John S. Williams M.D. Cumberland 1-14-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan 17 1954
NAME OF CEMETERY OR CREMATORY Union Cemetery
LOCATION (City, town, or county) (State) Meyersdale Pennsylvania
DATE REC'D BY LOCAL REGISTRAR Jan 14 1954
REGISTRAR'S SIGNATURE Walter R. Lantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc.
ADDRESS Cumb. Md.

VS. A15

RECEIVED
JAN 19 1954
BUREAU V. S.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00057/

1 PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 8/11/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland, Rural
STREET ADDRESS (If rural give location) 274 Narrows Park, R.F.D. #6

3. NAME OF DECEASED: (Type or Print) (First) Lillie (Middle) (Last) Ridgely
4. DATE OF DEATH: (Month) (Day) (Year) January 20, 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 8/6/1868
9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life (even if retired): Formerly Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles Ridgely
14. MOTHER'S MAIDEN NAME: Elizabeth Thrasher
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Pulmonary Hypostasis — 24 hrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Chronic Myocardial Degeneration — ?
DUE TO
(c) Cerebral Arteriosclerosis — ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis — ?

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952, to Jan. 20, 1954, that I last saw the deceased alive on Jan. 19, 1954, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) James E. McClean M.D. — ADDRESS 49 Greene St. — DATE SIGNED 1-20-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan 22 1954 — NAME OF CEMETERY OR CREMATORY Rose Hill Cem. — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Jan 2, 1954 — REGISTRAR'S SIGNATURE Winter R. Lantz M.D. — 24. FUNERAL DIRECTOR Charles L. George — ADDRESS Cumb. Md.

RECEIVED
JUN 1954
BUREAU V. S.

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00058

Reg. Dist. No. 4

0039

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
STREET ADDRESS (If rural give location) 17 W. OLDTOWN ROAD

3. NAME OF DECEASED: (Type or Print) (First) Lois ~~LOUIS~~ (Middle) Lorraine ~~LORRINE~~ (Last) ROBINSON

4. DATE OF DEATH: (Month) JANUARY (Day) 31 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: JULY 14 1953
9. AGE last birthday: yrs. 6 MOS
IF UNDER 1 YEAR: Months 6 Days 17
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EARL D ROBINSON
14. MOTHER'S MAIDEN NAME: HELEN LECHLITER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X Immediate cause (a) Pneumonia Bilateral lobar (massive)

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Amyotonia Congenital

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Jan, 1954, to 31 Jan, 1954, that I last saw the deceased alive on 31 Jan, 1954, and that death occurred at 8:20 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B Whitworth MD
ADDRESS 123 Bedford St
DATE SIGNED 31 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 2, 1954
NAME OF CEMETERY OR CREMATORY St Marys Cemetery
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 1, 1954
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md.
ADDRESS

7/32124

BUREAU V. S.

Within corporate limit

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0040

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 00059

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W.Va. COUNTY Mineral

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Fort Ashby

STREET ADDRESS (If rural, give location) R.F.D. #2 Keyser, W.Va.

3. NAME OF DECEASED: (Type or Print) (First) Myrtle (Middle) May (Last) Robinson

4. DATE OF DEATH (Month) Jan. (Day) 13 (Year) 1954

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: May 9-1905

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rural) near Keyser, W.Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles B. Newhouse

14. MOTHER'S MAIDEN NAME: Rose Cannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: (son) Walter B. Robinson, Fort Ashby, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

33/X

Immediate cause (a) Cerebral hemorrhage (apoplexy) — INTERVAL BETWEEN ONSET AND DEATH about 1 hr.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Jan. 14-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan. 17, 1954

NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Jan. 15, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Light

ADDRESS " "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06060

Reg. Dist. No. 4

0041

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 7/25/53

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing

STREET ADDRESS (If rural give location): State Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Maude	Estelle	Ryan	January	4,	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married	May 3, 1882	71 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Mt. Savage, Maryland	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Trimble	Helen Trimble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	No	None	Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
42.2.2 Immediate cause	(a) Pulmonary Hypostasis.	48 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Chronic Myocarditis,	?
260X	DUE TO (c) Pernicious anemia	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	?

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 25, 1953, to Jan. 4, 1954 that I last saw the deceased alive on Jan. 4, 1954, and that death occurred at 11 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Harold E. McLean M.D. — ADDRESS: 49 Greene St. — DATE SIGNED: 1-4-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 7, 1954	Eckhart Cemetery.	Eckhart, Maryland.

DATE REC'D BY LOCAL REGISTRAR: Jan 7, 1954 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: George Eichhorn, Lonaconing, Md.

VS. A15

Within corporate limits

0042

00061

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WHITWORTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 3 HRS. 15 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE
STREET ADDRESS (If rural give location) ROUTE #2

3. NAME OF DECEASED: (Type or Print) (First) BABY (Middle) BOY (Last) SELF

4. DATE OF DEATH: (Month) JANUARY (Day) 13, (Year) 19 54

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: JAN. 13, 1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 3 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALVIN E. SELF
14. MOTHER'S MAIDEN NAME: HELEN RUTH SOMERVILLE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0

Immediate cause (a) Cerebral Anoxia DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Thrombosis Umbilical Cord DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 13 Jan, 1954, to 13 Jan, 1954, that I last saw the deceased alive on 13 Jan, 1954, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B. Whitworth
ADDRESS 123 Bedford St Cumb. Md
DATE SIGNED 13 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation
DATE THEREOF Jan. 13, 1954
NAME OF CEMETERY OR CREMATORY Memorial Hospital
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 13, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Memorial Hospital, "
ADDRESS "

2014347362

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN
BUREAU V. S.

Within corporate limits

0143 M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00062

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death must be certified by a physician. If the deceased was under one year of age, the exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Memorial Hospital
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Memorial Avenue, Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Hazelton, W.Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hazelton W. Va
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Ora (Middle) Roy (Last) Shaffer
4. DATE OF DEATH: (Month) January (Day) 21 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 17 1876	77 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	West Virginia	U.S.A.

13. FATHER'S NAME: Alexandria Shaffer
14. MOTHER'S MAIDEN NAME: Mary Ringler

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No.	None	Memorial Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) Mesenteric thrombosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Adenocarcinoma of lower sigmoid DUE TO

(c)

Interval Between Onset And Death: 1/19/54 a m; 6 months before operation

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Generalized arteriosclerosis, last several years

19a. DATE OF OPERATION: 9/16/53
19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of the lower sigmoid.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20, 19 54 to 1/21, 19 54, that I last saw the deceased alive on 1/21, 19 54 and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
C. Mercia MD Cumberland Md. 1-22-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 25 1954	Hazelton Cem	Hazelton W Va.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 22, 1954	Walter K. Bantz, M.D.	Louis Stein Inc.	Cumb. Md.

VS. A15

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AU V. S.

0065

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00063

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1/2 hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Zihlman, Frostburg, Md.
STREET ADDRESS (If rural give location) R. D. No 2. Box 234

3. NAME OF DECEASED: (Type or Print) (First) Geraldine (Middle) (Last) Shoemake

4. DATE OF DEATH: (Month) 1 (Day) 15 (Year) 1954

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Feb. 6-1953
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months 11 Days 9 IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Shoemake
14. MOTHER'S MAIDEN NAME: Lois Duffenbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Box 234, Frostburg Md. Mrs Robert Shoemake, R. D. No 2.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO Pneumonia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 5 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Possible Congenital Heart Disease ~~[illegible]~~ 11 mos.

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION ✓
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from JAN. 15, 1954, to JAN. 15, 1954, that I last saw the deceased alive on JAN. 15, 1954, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Martin Nothstein M.D. ADDRESS 48 Broadway. Frostburg, Md. DATE SIGNED 1/16/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1-17-1954 NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-16-54 REGISTRAR'S SIGNATURE Mr Nancy N. Roe
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. ADDRESS

JAN 15
BUREAU V.

Within corporate limits

0044

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00064

CERTIFICATE OF DEATH

DR. FAW

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 32 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 629 NORTH CENTRE STREET

3. NAME OF DECEASED: (Type or Print) (First) CORA (Middle) M. (Last) SHROYER

4. DATE OF DEATH: (Month) JANUARY (Day) 21, (Year) 19 54

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: 10/25/1897
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): BOOKKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: Woolworth Store
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SHROYER
14. MOTHER'S MAIDEN NAME: MARY KORNRUMPT.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 214-05-5259
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

155x

Immediate cause (a) Carcinoma of liver, Primary — Interval Between Onset And Death: Approx 1 yr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct 1953
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Liver, Primary
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1953, to Jan 21, 1954, that I last saw the deceased alive on Jan 20, 1954, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W M Faw Jr. MD
ADDRESS Cumberland Md
DATE SIGNED Jan 21 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan 24 1954
NAME OF CEMETERY OR CREMATORY Greenmount Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 22, 1954
REGISTRAR'S SIGNATURE Winter K. Frantz M.D.
24. FUNERAL DIRECTOR William H Kight
ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN
AU V. S.

Within corporate limits

00065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be certain age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 31. Marion Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 31. Larion Street

3. NAME OF DECEASED: (Type or Print) (First) Myrtle (Middle) (Last) Smith

4. DATE OF DEATH: (Month) Jan. (Day) 30, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug 24 1888

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Bedford County, Penna

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Bell

14. MOTHER'S MAIDEN NAME: Barbara Ann Miller

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Viola A. Smith, 31 Marion St, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 420.1 Acute Coronary Occlusion DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 12 hours

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-29 1954 to 1-30 1954, that I last saw the deceased alive on 1-29, 1954, and that death occurred at 7 A.M. from the causes and on the date stated above.

SIGNATURE Rev. [illegible] M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial

DATE THEREOF Feb 2 1954

NAME OF CEMETERY OR CREMATORY Fairview Cemetery

LOCATION (City, town, or county) (State) Artemas, Bedford Co, Pa.

DATE RECD BY LOCAL REGISTRAR Feb. 1, 1954

REGISTRAR'S SIGNATURE Dantes K. Frantz, M.D. ADDRESS

24. FUNERAL DIRECTOR William H. Kight Cumberland, Md.

Dr. Johnson

RECEIVED
FEB
BUREAU V. S

00066

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No. 4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0046

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Cumberland

LENGTH OF STAY (in this place): 2 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Potomac River, rear Girls Scout home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md. — COUNTY: Allegany

CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland

STREET ADDRESS (If rural, give location): 131 Paca St.

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Edward (Last) Smith Jr.

4. DATE OF DEATH (Month) Jan. (Day) 19 (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug. 16-1945

9. AGE last birthday: 8 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: West Side School

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Edward Smith Sr.

14. MOTHER'S MAIDEN NAME: Frances Lytton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: (step-mother) Thelma G. Smith, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

929.8

Immediate cause (a) Shock & asphyxia due to drowning. — INTERVAL BETWEEN ONSET AND DEATH: about 3

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Sled riding on ice, ice broke and he fell minutes.

DUE TO

(c) in the water.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac river

21c. (City or town) Cumberland (County) Allegany (State) Md.

21d. TIME OF INJURY (Month) Jan. (Day) 19/54 (Year) about 4:50 P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Broke through ice while sled riding.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. V. Deming M.D. — M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED: Jan. 19-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 22, 1954 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county): Cumberland, Maryland (State)

DATE REC'D BY LOCAL REG.: Jan. 21, 1954 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Charles L. George, " — ADDRESS: "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
JAN
BUREAU V. S.

DR. R. J WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00067

0047

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGHANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGHANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 119 MASSACHUETTS AVE.

3. NAME OF DECEASED: (Type or Print) (First) FREDERICK (Middle) ~~D~~ E. (Last) SNYDER

4. DATE OF DEATH: (Month) JANUARY (Day) 9 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: AUGUST 30, 1891

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): PIPEFITTER

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R. Co.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SNYDER

14. MOTHER'S MAIDEN NAME: SARAH SHANK

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-05-4778

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X

Immediate cause (a) Carcinoma of Stomach — Interval Between Onset And Death 4 mo.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) — — —

DUE TO

(c) — — —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. — — —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/1/53, 19 ..., to 1/9/54, 19.., that I last saw the deceased alive on 1/9/54, 19 and that death occurred at 6:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. Williams M.D. ADDRESS Cumberland DATE SIGNED 1/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan. 12, 1954

NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

LOCATION (City, town, or county) Cumberland, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

JAN 3 1934
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00068

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) Rear 454 Walnut St.

3. NAME OF DECEASED: (Type or Print) (First) Patricia (Middle) Anne (Last) Stein
4. DATE OF DEATH: (Month) JAN. (Day) 15 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: June 7 1952
9. AGE last birthday: 1 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Paul J Stein Jr.
14. MOTHER'S MAIDEN NAME: Sara Jane Lee

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Paul J Stein Jr. Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 490X (a) Pneumonia Bilateral Lobar Massive — Interval Between Onset And Death 1 Day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dehydration – Streptococcus Mutans

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-14, 1954, to 1-15, 1954, that I last saw the deceased alive on 1-15, 1954, and that death occurred at 4:30 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B Mutton M.D. ADDRESS 123 Bedford St. DATE SIGNED 18 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/18/54
NAME OF CEMETERY OR CREMATORY St. Peter & Pauls Ln
LOCATION (City, town, or county) (State) Cumberland
DATE REC'D BY LOCAL REGISTRAR Jan. 18, 1954
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 23 1
BUREAU V. S.

Within corporate limits

0049

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 000694

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 7 Wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 604 Bedford Street

3. NAME OF DECEASED: (Type or Print) (First) Elsie (Middle) (Last) Stewart
4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: June 6, 1906
9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Midlothian, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bear Cole
14. MOTHER'S MAIDEN NAME: Hattie Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Edward Stewart, Cumberland, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

Immediate cause (a) Uremia

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Hypertensive C.V. Renal Disease

DUE TO (c)

Interval Between Onset And Death: 1 month / year

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany 1, 1953, to Jany 22, 1954, that I last saw the deceased alive on Jany 21, 1954, and that death occurred at 4136 Bay, from the causes and on the date stated above.

SIGNATURE B M Schindler MD (Degree or title) ADDRESS 411 Greene St Cumberland Md DATE SIGNED 1-22-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 25, 1954
NAME OF CEMETERY OR CREMATORY Woodlawn Bur. Park
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland ADDRESS

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BUREAU V. S.

0077 Film#G160 Item# 9 1/11/54 emp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 66370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Flintstone
LENGTH OF STAY (in this place) 9 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. #2 Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (rural) Flintstone
STREET ADDRESS (If rural, give location) R.F.D. #2 Cumberland, Md.

3. NAME OF DECEASED: (Type or Print) (First) Henry (Middle) Harrison (Last) Teeter

4. DATE OF DEATH (Month) Jan. (Day) 2 (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	April 8-1905	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ground Keeper -	Cumberland Country Club near Petersburg, W.Va.		U.S.A.

13. FATHER'S NAME: Benjamin Teeter

14. MOTHER'S MAIDEN NAME: Emily Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	211-05-6118	(wife) Viola Teeter, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
976X Immediate cause	(a) Exsanguination due to a 12 gauge (Stevens)	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) shotgun blast, muzzle of gun in mouth, discharged,	
	DUE TO (c) shattering right side of face and skull.	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Despondent.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
0		

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
	Home	near- Flintstone Allegany Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
Jan. 2-1954-7AM		Shot himself with a 12 gauge shotgun.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Jan. 2-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 7 1954	Glendale Cemetery	Flintstone, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 5, 1954	Harry Bender mat.	William H. Kight,	Cumberland, Md.

VS. A15A - 5 - 53

RECEIVED
JAN 7 1954
BUREAU V

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06071

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 2—
LENGTH OF STAY (in this place) 12 yrs-5mo. 7days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS SYLVAN RETREAT

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) (Last) THOMAS

4. DATE OF DEATH: (Month) I (Day) 5 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: Oct, 21.1870

9. AGE last birthday: 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William r. Thomas

14. MOTHER'S MAIDEN NAME: Rebecca Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. John Marshall, Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause 422.1	(a) Chronic Myocardial Degeneration	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Generalized arteriosclerosis	?
	DUE TO (c) Senility	?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia — 12½ yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952 to Jan. 5th 1954, that I last saw the deceased alive on Jan. 4, 1954, and that death occurred at 9:10 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) James E. McLean M.D. ADDRESS 49 Grant St. DATE SIGNED 1-6-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Jan. 7, 1954

NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery

LOCATION (City, town, or county) (State) Lonaconing, Md.

DATE REC'D BY LOCAL REG. Jan. 7, 1954

REGISTRAR'S SIGNATURE Winter R. Beatty, M.D.

24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md. ADDRESS

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00072

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Thompson (Last)
4. DATE OF DEATH: (Month) January (Day) 9 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: June 20, 1897
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Steel Worker
10b. KIND OF BUSINESS OR INDUSTRY: Geo. F. Hazelwood Construction Co.
11. BIRTHPLACE (State or foreign country): Colgate, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Thompson
14. MOTHER'S MAIDEN NAME: Jennie Wilson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-6412
17. INFORMANT & ADDRESS: Mrs. Lucinda Thompson, Cresaptown, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause 420.1 (a) Coronary occlusion — 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Emphysema. — 4 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-23, 1950, to 1-9, 1954, that I last saw the deceased alive on 1-9, 1954, and that death occurred at 7:30 pm., from the causes and on the date stated above.

SIGNATURE Ralph W. Bullin (Degree or title) M.D. ADDRESS 62 Greene St Cumberland Md DATE SIGNED 1-11-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan 17, 1954
NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park
LOCATION (City, town, or county) (State) Frostburg, Maryland
DATE REC'D BY LOCAL REGISTRAR 1/11-54
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

Within corporate limits

0051

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00073 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 71 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 638 N. Mechanic St

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) Victoria (Last) Twigg
4. DATE OF DEATH: (Month) Jan (Day) 26 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: July 3 1882
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Private Home
11. BIRTHPLACE (State or foreign country): Cumberland, Allegany Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Frantz
14. MOTHER'S MAIDEN NAME: Annie L. Burkett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Carl L. Twigg, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Heart Failure — Interval Between Onset And Death: 3 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertension Heart Disease — 3 x 4 yrs

DUE TO (c) Cerebral Hemorrhage — Dec 10 53

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1957, to Jan 26, 1954, that I last saw the deceased alive on Jan 25 1954, and that death occurred at 4-20 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] ADDRESS Cumberland Md DATE SIGNED Jan 27/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan 28 1954
NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

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Twigg

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

000744

CERTIFICATE OF DEATH

Reg. Dist. No. ... .

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown ,Md.
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oldtown,Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown,Md.
STREET ADDRESS (If rural give location) Oldtown,Maryland

3. NAME OF DECEASED: (Type or Print) (First) Maggie May (Middle) Twigg (Last)

4. DATE OF DEATH: (Month) I-20- (Day) (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: I-20-1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Allegany County

11. BIRTHPLACE (State or foreign country): Oldtown,Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles F. Twigg

14. MOTHER'S MAIDEN NAME: Hannah C. Goldsborough

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Mary Light Cumberland,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

345X

Immediate cause (a) Multiple Sclerosis — Interval Between Onset And Death: 10 yrs

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — 10 yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1940, to Jan 20, 1953, that I last saw the deceased alive on Oct., 1953, and that death occurred at 2:00 AM, from the causes and on the date stated above.

SIGNATURE N. W. Eleason (Degree or title) MD. ADDRESS 126 Union St Cumberland Md. DATE SIGNED 1/20/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF I-23-54

NAME OF CEMETERY OR CREMATORY Wilson Cem.

LOCATION (City, town, or county) (State) Wilson Rd. near Oldtown,Md

DATE REC'D BY LOCAL REGISTRAR Jan 21, 1954

REGISTRAR'S SIGNATURE Fay Duckworth mgr.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland,Md.

RECEIVED
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BUREAU V. S.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00075

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 50 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 315. Bedford Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 315 . Bedford Street

3. NAME OF DECEASED: (Type or Print) (First) Clara (Middle) Myrtle (Last) Van Horn

4. DATE OF DEATH: (Month) January (Day) 18 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Nov 2 1876

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ~~House Home~~

11. BIRTHPLACE (State or foreign country): Hazen, Allegany Co, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B. Brandt

14. MOTHER'S MAIDEN NAME: Sarah Alice Shields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. William Henry, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 4-43X (a) Chronic Myocardial Degeneration

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c) Essential Hypertension

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10.1, 1951, to 1-18-, 1954 that I last saw the deceased alive on 1-14, 1954, and that death occurred at 3 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) W. L. Williams M.D. ADDRESS Cumberland DATE SIGNED 1-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan 21 1954

NAME OF CEMETERY OR CREMATORY Centenary Cemetery

LOCATION (City, town, or county) Near Cumberland (State) Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 20, 1954

REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

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00076

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (Rural) Danville

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 220

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Va. COUNTY:

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Arlington

STREET ADDRESS (If rural, give location): 1005 N. Vermont St. ✓

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Franklin	Wagoner	Jan.	31	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	Feb. 15-1927	26 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Mgr. Auto Sales	Used Cars.	Cumberland, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frank D. Wagoner	Leona Grace Barker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	234-38-8177	Mrs. John Newhouse, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

824X

Immediate cause — (a) Shock, intrathoracic & Intra-abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) crushed chest, fractured pelvis, both clavicles, both humerous, right forearm, lower maxillary & dorsal verte-

DUE TO — (c) Automobile accident. — brae

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AU... Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	highway	rural Dawson	Allegany	Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: Jan. 31/53 A. M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
1:10		Excessive speed, lost control of auto, thrown out.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D.

DATE SIGNED: Jan. 31-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
Burial	Feb. 3 1954	Queens Point Cem.	Keyser, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4 1954	Mrs. Jean C. Kelley	Rogers Funeral Home, Keyser, W. Va.	
Feb 2, 1954			

0066

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00077

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Avilton
STREET ADDRESS — (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Ronald (Middle) Allan (Last) Wallace

4. DATE OF DEATH: (Month) Jan (Day) 14 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Infant
8. DATE OF BIRTH: Jan 11 1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Frostburg Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald C Wallace
14. MOTHER'S MAIDEN NAME: Irva Roheson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Frank Roheson - Avilton Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

769.5

Immediate cause (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 3 Days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Maternal Nephritic Toxemia

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 11, 1954, to Jan 14, 1954, that I last saw the deceased alive on Jan 14, 1954, and that death occurred at 8:55 A.M. m., from the causes and on the date stated above.

SIGNATURE W O McLane MD (DEGREE OR TITLE) ADDRESS Frostburg Md DATE SIGNED Jan 14 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF 1-16-54 NAME OF CEMETERY OR CREMATORY Trinity Reformed LOCATION (City, town, or county) New Germany (State) Grantsville

DATE REC'D BY LOCAL REG. 1-14-54 REGISTRAR'S SIGNATURE Mr Nancy H Roe

24. FUNERAL DIRECTOR Wm Winterberg ADDRESS Grantsville Md

RECEIVED
JAN 16
BUREAU V. S.

0054

DR. HODGES

Dr Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00078

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (In this place) 8 HR. 45 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE WEST VIRGINIA COUNTY Mineral
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) BABY (Middle) GIRL (Last) WELCH

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: JAN. 30, 1954

9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 8 Min. 45

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME: WELCH, WILLIAM W.

14. MOTHER'S MAIDEN NAME: FLICKINGER, BETTY J.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X

Immediate cause (a) Prematurity 30 wks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 19 .., to ..., 19..., that I last saw the deceased alive on ..., 19 , and that death occurred at 1:55 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B. Whitworth Jr. ADDRESS 123 Bedford St. DATE SIGNED 31 Jan 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan. 31, 1954 NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery LOCATION (City, town, or county) (State) Fort Ashby, West Virginia

DATE REC'D BY LOCAL REGISTRAR Jan. 31, 1954 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. 24. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

FEB

BUREAU V. S

6053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 — 36079

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frahamtown — LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Parell's Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frahamtown Frostburg
STREET ADDRESS (If rural give location) 10 Parell's Lane

3. NAME OF DECEASED: (Type or Print) (First) Land (Middle) J. (Last) Williams

4. DATE OF DEATH: (Month) 1 (Day) 9 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7-30-1902

9. AGE Last birthday: 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Celanese

11. BIRTHPLACE (State or foreign country): Frostburg, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Land Williams

14. MOTHER'S MAIDEN NAME: Jemima Wright

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-10-2149

17. INFORMANT & ADDRESS: Mrs Land J. Williams R.D. #1 Frostburg, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death 1 hour

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c) DUE TO

420.1

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 9, 1954, to Jan 9, 1954, that I last saw the deceased alive on Jan 9, 1954, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm C Lane M D — ADDRESS Frostburg Md — DATE SIGNED Jan 11 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-12-1954 — NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park — LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-13-54 — REGISTRAR'S SIGNATURE Mrs Nancy N. Roe

24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. (ADDRESS)

RECEIVED
JAN
BUREAU V. S.

Within corporate limits. Film #G160 Item # 14 1/21/54 emf

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00080

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 9/22/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) 52 Mechanic Street

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) A. (Last) Winebrenner
4. DATE OF DEATH (Month) January (Day) 11, (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 4/6/1860
9. AGE last birthday: 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Francis Graham
14. MOTHER'S MAIDEN NAME: Elizabeth Graham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

422.1

Immediate cause (a) Pulmonary Hypostasis — 24 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chronic Myocarditis — ?

DUE TO

(c) Cerebral arteriosclerosis — ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis — 1 yr.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 17, 1953 to Jan. 11th, 1954, that I last saw the deceased alive on Jan. 11th, 1954, and that death occurred at 3 p.m., from the causes and on the date stated above.

SIGNATURE James E. McLean M.D. (Degree or title) ADDRESS 49 Greene St. DATE SIGNED 1-12-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/14/54
NAME OF CEMETERY OR CREMATORY Johnson Cemetery
LOCATION (City, town, or county) (State) R D #40, Frostburg, Md.
DATE REC'D BY LOCAL REGISTRAR Jan. 13, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1954
BUREAU V. S.

Within corporate limits

0056

DR. ROTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00081

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND 2

LENGTH OF STAY (in this place): 8 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND — COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND 2

STREET ADDRESS (If rural give location): 118 HANOVER ST.

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): NORA WOODCOCK

4. DATE OF DEATH: (Month) JAN. (Day) 18 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED

8. DATE OF BIRTH: MAY 11, 1890

9. AGE last birthday: 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERMAN HINZE

14. MOTHER'S MAIDEN NAME: MARY HERRING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Congestive heart failure due to — Interval Between Onset And Death: 9 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Myocardial degeneration and arterio-

DUE TO (c) sclerotic cardio vascular disease — unk.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1953, to January 18, 1954, that I last saw the deceased alive on Jan 18, 1954, and that death occurred at 8:00 PM, from the causes and on the date stated above.

SIGNATURE (Degree or Title): Oliver Ralph Lock M.D. — ADDRESS: 202 Va. Ave. Cumberland Md — DATE SIGNED: 1/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-20-1954

NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan 20, 1954

REGISTRAR'S SIGNATURE: Walter K. Hantz M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

VS. A15

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JAN 26 1954
BUREAU V. S.